WASHINGTON STATE PROPOSAL ADDENDUM
HEALTH INNOVATION FOR WASHINGTON
(Prior title: *Global Medicaid Modernization Initiative***)**

BACKGROUND

On April 29, 2011, Governor Chris Gregoire transmitted a proposal to the U.S. Department of Health and Human Services (DHHS) outlining the next phase of bold action to transform Washington State's health care system. The original title for this proposal, *Global Medicaid Modernization Initiative*, has been reformulated to **HEALTH INNOVATION FOR WASHINGTON**. Governor Gregoire set a goal of reducing the overall trend in health care spending in Washington State to no more than four-percent annual per capita growth by 2014, while maintaining or improving patient health outcomes.

HEALTH INNOVATION FOR WASHINGTON responds to this goal through aggressive reforms in the following areas:

- Value Based Benefit and Payment Reform
- Delivery System Reforms
- Consumer Engagement
- Prevention and Wellness
- Administrative Simplification

Washington's proposal requested DHHS assistance in the planning, design, and implementation of reforms that will improve the health care delivery system while controlling costs. The response from DHHS was immediate and reflected a true sense of federal-state partnership. DHHS assigned a team (WA MSTAT) to work with the State Health Care Team; discussions will commence on May 20, 2011.

Specific requests in the form of flexibility, waivers, fiscal resources, and technical assistance from the Centers for Medicare & Medicaid Services (CMS) were included in the original proposal. This Addendum provides additional request details for purposes of discussion and negotiation.

For each area of reform, original requests from the State of Washington proposal are presented along with the State's initial interpretation of the specific federal statutory or regulatory provisions where flexibility or waivers are required. Requests for specific fiscal resources are also outlined in each area. HEALTH INNOVATION FOR WASHINGTON reforms that can be pursued within existing federal or state authority are not repeated in this addendum.

VALUE-BASED BENEFIT AND PAYMENT REFORM

Intent: A health care system where public and private payers and providers test, confirm, then adopt new, common business models that sustain a strong primary care base and promote the delivery of value-based, patient-centered care.

REQUEST: Maximum participation and alignment of Medicare and Medicaid in efforts to pay differently for services and care including – incenting managed care plans to utilize bundled payments or sub-capitation models; episode based reimbursement, capitation/global payments, shared savings or other incentive based payment system that rewards coordinating the continuum of care and optimizing value. This would also apply to services that are provided through the Medicaid fee-for-service system.

FEDERAL STATUTORY OR REGULATORY PROVISIONS:

- §§ 1903(m)(2) and 1932 (f) regarding payments to MCOs: "…such services are provided for the benefit of individuals eligible for benefits under this title in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis."
- 42 CFR §438.6(c)(2): "All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound."

REQUEST: Authority to apply and enforce an evidence-based prescription drug list.

FEDERAL STATUTORY OR REGULATORY PROVISIONS:

- § 1902(a)(54), to the extent it requires state compliance with 1927(d)(4)(B), requiring a state to include drugs in a formulary if the manufacturer has agreed to pay a rebate.

REQUEST: Authority to restrict choice of providers under certain circumstances to providers with specified performance standards, including those designated as Centers of Excellence.

FEDERAL STATUTORY OR REGULATORY PROVISIONS:

- § 1902(a)(23): "(A) Any individual eligible for medical assistance (including drugs) may obtain such assistance from an institution, agency, community pharmacy, or person, qualified to perform the service or services required … who undertakes to provide him such services."
- 42 CFR §431.51(a)(1): "Recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them."

REQUEST: Authority for non-comparability of payment among providers performing the same services with different risk-adjusted outcomes.

FEDERAL STATUTORY OR REGULATORY PROVISIONS:

- Possibly § 1902(a)(30): "… assure that payments are consistent with efficiency, economy, and quality of care."

REQUEST: Ability to adopt the ACA essential health benefits for both current and "new" Medicaid eligibility groups, with additional supplemental benefits for children, pregnant women, individuals with disabilities, and elderly adults.

FEDERAL STATUTORY OR REGULATORY PROVISIONS:

- § 1902(a)(10)(B): Medicaid "made available to any individual … shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual."
- § 1937: Permits state to mandate benchmark benefits for certain populations, but exempts mandatory pregnant women, blind or disabled individuals, dual eligible, terminally ill hospice patients, institutionalized individuals, medically frail and special medical needs individuals, beneficiaries qualifying for long-term care services, children in foster care receiving child welfare services and children receiving foster care or adoption assistance, TANF and section 1931 parents, women in the breast or cervical cancer program.
- 42 CFR §440.240: "The plan must provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient," and "the plan must provide that the services available to any individual in the following groups are equal in amount, duration, and scope for all recipients within the group: "(1) The categorically needy; (2) A covered medically needy group."

REQUEST: Engage in discussions on the possibility of pooling Medicaid and the Basic Health Plan option in a common risk pool for managed care coverage.

FEDERAL STATUTORY OR REGULATORY PROVISIONS:

- ACA § 1331(b)(4): "A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State Medicaid program under Title XIX of the Social Security Act, the State child health plan under Title XXI of such Act, and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care."

REQUEST: Funding to support necessary planning, design, development, implementation and evaluation activities related to Value Based Benefit and Payment Reform items including those which can be implemented within existing federal or state authority.

FISCAL RESOURCE REQUEST:

- Funding to: (1) support staff to manage the HEALTH INNOVATION FOR WASHINGTON request and implementation; (2) extend multi-payer pilot projects to a statewide scale; (3) support selective contracting and deeper discount purchasing; and (4) consultants and actuarial services for all aspects of payment reform.
    - TOTAL REQUEST for FY 2012 and FY 2012 - $4,356,000; includes 10.0 FTE

DELIVERY SYSTEM REFORMS

Intent: A health care system where care is integrated, culturally competent and responsive to the varying needs of rural and urban settings, where providers respond to routine reporting that highlights efficient and inefficient practices and where

consumers, providers, and payers make informed decisions for more effective and efficient use of health care resources.

REQUEST: Authorization to require all Medicaid adults and children to be enrolled in a health home that will provide safe, effective, person-centered, timely and accessible health care. This could include enrollment in a health plan that would be contractually required to provide the health home.

FEDERAL STATUTORY OR REGULATORY PROVISIONS:

- § 1932(a)(2): Bar on requiring certain children with special needs and Medicare beneficiaries to enroll in a managed care entity.
- § 1945: Gives states the option to pay providers to coordinate care through a "health home" for individuals with chronic conditions. States electing this option will be eligible for 90% federal match for the first eight quarters in which the state plan is in effect, after which the state will receive its regular FMAP.

REQUEST: Assistance in developing policy and financing models to support the "secondary health homes" model. Items for discussion include greater flexibility in the Money Follows the Person program, integrated waiver approaches that focus on individual needs rather than eligibility categories around which delivery silos are built – senior citizens, people with developmental disabilities, or people with mental health conditions -- and financing models that incent and reward collaboration with primary care health homes including shared savings. This will be facilitated by CMS leadership and coordination of discussions across CMS and with other DHHS agencies including the Substance Abuse and Mental Health Services Administration (SAMHSA), Administration for Children and Families (ACF), Administration on Aging (AoA), and Health Resources and Services Administration (HRSA) and with appropriate entities in the Department of Housing and Urban Development (HUD) and the Department of Agriculture to explore options for better coordination and possible blending of funding for health and social support services.

FEDERAL STATUTORY OR REGULATORY PROVISIONS:

- § 1915(c) and new proposed regulations at 42 CFR § 441.301, which would permit states to combine target groups.

REQUEST: Authority to require enrollment of individuals dually eligible for Medicare and Medicaid in organized health care systems that provide safe, effective, person-centered, timely, and accessible health care. This could include enrollment in a health plan that would be contractually required to provide the health home. Appropriate opt-out criteria for enrollment will be developed. Enrollment will be expected for a minimum period of time with appropriate criteria for changing plans developed. The state further seeks authorization to blend Medicare and Medicaid funding for the dually eligible population and will seek to negotiate an agreement between Medicare and the state to identify, capture and share Medicare savings.

FEDERAL STATUTORY OR REGULATORY PROVISIONS:

- § 1802(a): "Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency or person undertakes to provide him such services."
- § 1902(a)(23): "(A) Any individual eligible for medical assistance (including drugs) may obtain such assistance from an institution, agency, community pharmacy, or person, qualified to perform the service or services required … who undertakes to provide him such services."
- 42 CFR § 431.51(a)(1): "recipients may obtain services from any qualified Medicaid provider that undertakes to provide the services to them."

REQUEST: Approval of ACA Section 2703 planning grant and State Plan Amendment to expand health home and health team models for targeted populations of Medicaid adults and children with chronic medical conditions and/or serious and persistent mental illness. Washington anticipates submitting a planning grant request by April 30, 2011 and a state plan amendment by August 2011.

FEDERAL STATUTORY OR REGULATORY PROVISIONS:

- Requires CMS approval of planning request and State Plan Amendment once submitted.

REQUEST: Funding to support the development and implementation of standardized training systems for public health nurses, community health workers, and other appropriate team members to coordinate care and linkages over a broad range of health services.

FISCAL RESOURCE REQUEST:

- Current health home training efforts will be significantly expanded, focusing more on Medicaid providers. Training will reach a minimum of 300 practices that serve a significant portion of Medicaid, Medicare, and dual eligible enrollees each year using a regional training approach. These training efforts will be coordinated with regional Centers of Excellence. Training will continue to be available to all Washington State providers, but preference will be given to providing technical assistance to health home providers that provide a significant volume of services to Medicaid and Medicare populations, including federally qualified health centers and rural health clinics. Trainings will be offered to medical practice team and clinics to support their transformation to primary care health homes.
    - TOTAL REQUEST for FY 2012 and FY 2013 - $1,829,000; includes 7.2 FTE
- Funding to coordinate practice improvement strategies that focus on tobacco cessation within the integrated health home, specifically by reaching out to clinics and providers that primarily serve the Medicaid and uninsured patients. Additional resources supporting the Quitline will be necessary to handle the increased demand for this service.

- TOTAL REQUEST for FY 2012 and FY 2013 - $4,398,000

REQUEST: Funding to support necessary planning, design, development, implementation and evaluation activities related to Delivery System Reform items including those which can be implemented within existing federal or state authority.

FISCAL RESOURCE REQUEST:

- Funding to support efforts to integrate care for dual eligible individuals project that pilot approaches to align incentives, make consumer and expenditure information more available, develop methods for federal and state sharing of savings, coordinate care and integrate primary and secondary health home supports for people whose health costs are covered by both Medicare and Medicaid.
  - TOTAL REQUEST for FY 2012 and FY 2013 - $938,000; includes 1.0 FTE

- Funding will initiate phase one of the Duals project: expansion of Chronic Care Management (CCM) for high cost/high risk people engaged in the Aging and Disabilities Services Administration's community-based service system. Tasks include: (1) identify expansion sites; (2) train key staff at expansion sites on CCM process and fidelity standards; (3) establish liaison between expansion sites and evaluation partners; and (4) oversee the first ten months of rollout. This proposal focuses exclusively on clients receiving services in Mental Health, Long-Term Care, and Developmental Disabilities.
  - TOTAL REQUEST for FY 2012 - $292,000; includes .5 FTE

- Funding to expand the Prescription Monitoring Programs (PMP) to include all prescription drugs to enhance coordinated medication therapy management and improved patient outcomes. For example, a PMP for all prescription drugs will allow practitioners to: 1) identify dangerous drug interactions; 2) reduce overdose medication errors from duplicative therapy; 3) identify patients with prescription drug problems; 4) facilitate earlier intervention for patients who need substance abuse treatment; 5) reduce the quantity of controlled substances obtained by individuals who may be "doctor shopping;" and 6) allow for earlier detection of abuse trends.
  - TOTAL REQUEST for FY 2012 and FY 2013 - $1,711,000; includes 5.2 FTE

- Funding to all the Medicaid Purchasing Administration to determine the level of behavioral health needs that can be met through the emerging primary care base health homes and establish the linkages and capacity to integrate behavioral health supports into them. Tasks include: (a) define and include essential behavioral health benefits and accountability measures in managed care procurements and contracts; (b) develop and disseminate training and resources for prevention, screening, and brief intervention in primary health clinics and health homes; (c) develop systems to facilitate access between health homes and specialty behavioral health systems; and (d) provide project coordination, change management, and stakeholder engagement.
  - TOTAL REQUEST for FY 2012 and FY 2013 - $261,000; includes 1.0 FTE

- Funding to develop "secondary health home" models for those with severe or multiple chronic conditions, individuals with severe mental health/substance use disorders, and individuals with physical or developmental disabilities who require expanded services beyond those provided by a primary care health home.
    - TOTAL REQUEST for FY 2012 and FY 2013 - $523,000; includes 2.0 FTE

CONSUMER ENGAGEMENT

Intent: A health care system where consumers are informed and incented to take greater responsibility for managing their own health and where they have easy access to health facts, comparative information on costs and quality and available care options.

REQUEST: Authority to establish and enforce point-of-service variable cost-sharing on the part of Medicaid patients to encourage informed consumer behavior, promote utilization of primary and preventive care benefits, promote adherence to treatment regimens and discourage inappropriate use of specialty care for primary and preventive care purposes.

FEDERAL STATUTORY OR REGULATORY PROVISIONS:

- § 1916(f): With limited exceptions, "no deduction, cost sharing, or similar charge may be imposed under any waiver authority of the Secretary."
- § 1916a(a)(1): With some exceptions, "a State, at its option and through a State plan amendment, may impose premiums and cost sharing for any group of individuals (as specified by the State) and for any type of services."
- 42 CFR §§ 447.50 *et seq.*

REQUEST: Medicaid participation in prevention investments including financing of Quit Line/Health Line and the Prescription Monitoring Program.

FEDERAL STATUTORY OR REGULATORY PROVISIONS:

- § 1905(a): Defining services eligible for reimbursement.

REQUEST: Funding to support necessary planning, design, development, implementation and evaluation activities related to Consumer Engagement items including those which can be implemented within existing federal or state authority.

FISCAL RESOURCE REQUEST:

- Funding to support the design and implementation of initiatives that engage consumers as active partners in controlling the growth of health care spending. Funding will primarily support: 1) design and implement cost sharing options to promote the use of cost-effective treatments, devices and providers; 2) promote adherence to treatment regimens that improve patient health outcomes; and 3) expand the proven Washington State Quit Line model for tobacco cessation to include obesity prevention activities.

- TOTAL REQUEST for FY 2012 and FY 2013 - $1,066,000; includes 1.0 FTE

PREVENTION AND WELLNESS:

Intent: Connect prevention-focused health care and community efforts to increase preventive services. Both clinical and community-based prevention are central to improving and enhancing health. Clinical and community prevention efforts need to be mutually reinforcing – individuals need to receive appropriate preventive care in clinical settings (for example, primary care providers should counsel their patients about the benefits of not smoking or of quitting if they do smoke) and also be supported by community-based resources (such as telephone quitlines that help people stop using tobacco). Identifying and supporting preventive clinical efforts in a variety of sectors, e.g., worksites, is an important component to the early identification of health problems and to enhancing health.

REQUEST: Financial participation in support of regional *Centers for Excellence* to promote community-based solutions aimed at preventing chronic disease and addressing the risk factors of chronic disease that contribute to high costs of health care.

FISCAL RESOURCE REQUEST:

- Funding to support regional "Centers of Excellence," which will coordinate community and clinical based solutions to prevent disease within their communities through improving access to healthy foods, physical activity, tobacco cessation services and tobacco free living, and quality clinical preventive services.
  - TOTAL REQUEST for FY 2012 and FY 2013 - $2,469,000; includes 5.1 FTE

- Funding to implement a statewide paid media campaign targeting low socio-economic status adult smokers that encourages them to quit and to get help by calling the tobacco Quitline. Paid media is an evidence-based strategy to prompt tobacco users to make a quit attempt. The primary goal of the prevention efforts is to reduce smoking rates among people of low socio-economic status (defined as people with less education) to decrease the current and future burden on the Medicaid system.
  - TOTAL REQUEST for FY 2012 and FY 2013 - $2,398,000; includes .2 FTE

REQUEST: Assistance with increasing collaboration and communication between Washington's Healthy Communities Partnership and federal agencies (aligned with National Prevention Council).

FISCAL RESOURCE REQUEST:

- Funding for work with the Healthy Communities statewide Partnership to: (a) identify gaps in policies and programs in communities that are perceived as removable barriers to creating and sustaining physical, social and economic environments; (b) develop advocacy policy recommendations that can lead to measureable environmental and systems changes to make healthy choices easy and improve quality of life in Washington communities; and (c) implement a statewide communication campaign designed to educate and promote wellness and prevention.
  - TOTAL REQUEST for FY 2012 and FY 2013 - $200,000

ADMINISTRATIVE SIMPLIFICATION

Intent: Reduce administrative costs for public and private health care entities through timely and efficient processing of business transactions between providers, payers and government. Simplify eligibility and enrollment processes to facilitate initial and continuing health care coverage for individuals.

REQUEST: Demonstration project that would allow the ACA Modified Adjusted Gross Income (MAGI) methodology to be used for determining eligibility for adults eligible for Medicaid, Basic health option and subsidized coverage in the state's Health Benefits Exchange. The use of MAGI would allow for a more seamless eligibility process for persons whose incomes change overtime and move between Medicaid and the Exchange and avoid expensive modifications to the state's Automated Client Eligibility System (ACES).

FEDERAL STATUTORY OR REGULATORY PROVISIONS:

- § 1902(a)(17): Requiring a State plan to provide a method for "determining eligibility for and the extent of medical assistance under the plan which … are consistent with the objectives of this title."

REQUEST: Engage in discussions regarding options for allowing low-income persons to retain their existing plan and coverage during the year when their income transfers their coverage between Medicaid and the Exchange.

FEDERAL STATUTORY OR REGULATORY PROVISIONS:

- § 1902(a)(10) regarding Medicaid eligibility
- I.R.C. § 36B(c)(2)(B): Subsidy only available if individual is not eligible for minimum essential coverage, including Medicaid.
- 42 CFR 435.916: "The agency must re-determine the eligibility of Medicaid recipients, with respect to circumstances that may change, at least every 12 months."

REQUEST: Funding to support necessary planning, design, development, implementation and evaluation activities related to Administrative Simplification items including those which can be implemented within existing federal or state authority.

FISCAL RESOURCE REQUEST:

- Funding for three administrative simplification initiatives which will improve the accuracy and efficiency of health care data: (1) implementation of a secure provider portal to access information and systems of multiple payers; (2) creation of a single source of provider credentialing; and (3) development of an electronic process that would allow medical providers to submit requests for prior authorization of payment for services.
    - TOTAL REQUEST for FY 2012 and FY 2013 - $2,355,000

STAKEHOLDER INVOLVEMENT

As Washington State engages with HHS/CMS in negotiating the HEALTH INNOVATION FOR WASHINGTON proposal, it will seek the input of Medicaid consumers and their representatives, Tribes, public and private providers including health plans and Regional Support Networks, other public purchasers, local government and the general public. An organized process for receiving input from and transmitting information to stakeholders will be employed. Frequent opportunities for review and input including use of focus groups and opportunities to comment on draft materials will be provided. Regular updates and reports will be provided to the Joint Legislative Select Committee on Health Reform Implementation.

REQUEST: The assistance of DHHS/CMS in the form of resources to support stakeholder engagement activities.

FISCAL RESOURCE REQUEST:

- Funding will support communication and facilitation effort to engage providers, consumers, associations and private and public partners and other efforts to discuss payment reform, service changes, and changes to consumer behavior.
    - TOTAL REQUEST for FY 2012 and FY 2013 - $1,878,000; includes 6.0 FTE